Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DIPTI PATEL DC
6660 AIRLINE DR.
HOUSTON TX 77076

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
ACE AMERICAN INSURANCE CO

Carrier's Austin Representative Box
Box Number 15

MFDR Tracking Number
M4-08-0290-02

MFDR Date Received
SEPTEMBER 14, 2007

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position summary with the request for medical fee dispute resolution.

Amount in Dispute: $1,416.79

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: the respondent did not submit a response to the request for medical fee dispute resolution

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 7, 2007 through April 26, 2007	Physical Therapy Services	$1,416.79	$1,416.79

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute
2. 28 Texas Administrative Code §134.203 sets out the guidelines for reimbursement of professional services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W11 – Entitlement to benefits. Not finally adjudicated.
   - (880-101) – Allowance denied: The claim is being disputed by the carrier/adjuster.
   - (880-197) – Denial Code E – Entitlement to benefits.
   - W2 – Workers' compensation claim adjudicated as non-compensable. Carrier not liable for claim or service/treatment.
   - (880-212) – Claim denied.
   - 214 – Workers Compensation claim adjudicated as non-compensable. This payer not liable for claim or

service/treatment.
- 218 – Based on entitlement to benefits.

Issues

1. Was the compensability issue adjudicated?
2. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier filed a PLN-11 disputed "any indemnity benefits, medical benefits and an injury in the course and scope of employment." A benefit review conference was held on March 7, 2008 to mediate resolution of the disputed issues; however, the parties were unable to reach an agreement. A contested case hearing was held on July 31, 2008 to decide if the claimant sustained a compensable injury on March 5, 2007.

   The decision of the Hearing Officer, signed August 4, 2008 was that the claimant sustained a compensable injury on March 5, 2007; the carrier is not relieved from liability under Texas Labor Code Ann. §409.002; and the claimant sustained disability beginning on March 6, 2007 and continuing through the date of the hearing. The Hearing Officer's order was that the carrier is ordered to pay benefits in accordance with this decision, The Texas Workers' Compensation Act, and the Commissioner's Rules. Therefore, the disputed dates of service will be reviewed in accordance with Division rules and the Labor Code
2. Per 28 Texas Administrative Code §134.202(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section..

   28 Texas Administrative Code §134.202(c) states, in pertinent part, "for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%. For Anesthesiology services, the same conversion factor shall be used.

   - CPT Code 97032: $15.50 x 125% = $19.38 x 14 Units = $271.32
   - CPT Code 97035: $14.65 x 125% = $14.56 x 6 Units = $87.36
   - CPT Code 97140: $25.51 x 125% = $31.89 x 14 = $446.46
   - CPT Code 99212: $37.64 x 125% = $47.05 x 13 = $611.65

   Review of the submitted documentation finds that the documentation submitted by the requestor supports the services were rendered as billed.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $1,416.79.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,416.79 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 29, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.